STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315014	A. BUILDING _____ B. WING _____	C 09/07/2023

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BIG OAK REHABILITATION AND HEALTHCARE CENTER	849 BIG OAK ROAD PITTSGROVE, NJ 08318

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F 000	INITIAL COMMENTS Standard Survey Complaint # NJ 160885, NJ 160875, NJ 161663, NJ 163965, NJ 164120, NJ 164276, NJ 165154, NJ 165680, NJ 166441 Census: 73 Sample Size: 23 + 1 closed record The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation it was determined that the facility failed to ensure residents call device was within reach of the residents. The deficient practice occurred for 2 of 5 residents (Residents #38, #32). The deficient practice was evidenced by the following: A.) On 08/24/2023 at 09:43 AM, during the initial tour of the facility, Surveyor #1 observed Resident #38 in bed in his/her room. Surveyor #1 observed	F 558	Upon being made aware of the concerns on 9/6/23 the facility corrected all of the issues to ensure residents have the means to call staff directly for assistance. Residents #38 and #32 identified in Statement of Deficiency (SOD) identify their needs through other means besides utilizing call bell and all needs were met. Resident #32 is NJ Exec Order 26.4b1 [redacted] and all needs are met with her verbalizing and routine rounding. Resident #38 Needs are to be met by the staff continue to anticipate the needs with	9/15/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/29/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 558	Continued From page 1 the call device attached to the cord near the wall input out of reach from the resident. On 08/28/2023 at 09:57 AM, Surveyor #1 observed Resident #38 in bed in his/her room. Surveyor #1 observed the call device attached to the cord near the wall input out of reach from the resident. On 08/29/2023 at 08:48 AM, Surveyor #1 observed Resident #38 in bed in his/her room. Surveyor #1 observed the call device attached to the cord near the wall input out of reach from the resident. At that time, Surveyor #1 activated the call device to ensure it worked. Once the call device was activated, the light outside of the room illuminated, an audible sound could be heard, and facility staff began to walk towards the doorway. A review of Resident #38's Care Plan revealed a Care Plan focus for the potential for [redacted] A further review of the Care Plan revealed an intervention revised on [redacted] that the call light is within reach, and [redacted] as needed. On 09/05/2023 at 12:40 PM, during an interview with Surveyor #1 and Surveyor #2, Certified Nursing Assistant (CNA #1) replied, "The policy is to answer them as soon as possible" when asked what the policy on call devices was. CNA #1 also replied, "They [call devices] should be placed by the resident if they sit in their chairs or by the bed if they are in bed" when asked where should call devices be placed. On 09/06/2023 at 12:53 PM, during an interview	F 558	rounding every 2 hours. The unit manager in serviced the Certified nurses assistant (CNA) #1 on the importance of the proper placement of call bells for resident access or other individual means of communication. All residents of the facility have had the potential to be affected by the deficient practice noted in the Statement of Deficiency (SOD). An audit was completed, and no residents were found to have been negatively affected. On 9/6/23 the entire staff had an immediate extensive in person in-service provided by the Director of Nursing related to the proper placement of call bells for the residents, or other individual means of communication to allow the residents the means to call staff directly for assistance. The DON/ADON will conduct bi-weekly audits for three weeks, weekly for three weeks, and monthly thereafter. The results of the audits will be reported to the facility monthly QAPI committee meeting for one quarter to determine if sufficient compliance has been met. Based on the results of the audit the QAPI committee will determine continued need for the audit.	

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F 558	Continued From page 2	F 558		

with Surveyor #1, the Licensed Nursing Home Administrator (LNHA) stated, "Within reach. They [residents] need access to call for help" when asked where should call devices be placed within a resident's room. The LNHA replied, "No" when asked by Surveyor #1 if call devices should be attached to the cord by the wall input while the resident is in bed.

B.) On 08/24/2023 at 11:52 AM, during the initial tour, Surveyor #2 observed Resident #32 awake in bed. Resident #32's call device was clipped to a cord extending from the wall. Resident #32 could not reach the device.

On 08/25/2023 at 09:10 AM, Surveyor #2 observed Resident #32 resting in bed. The call device was clipped to a cord extending from the wall. The device was not in reach of Resident #32.

On 08/29/2023 at 08:52 AM, Surveyor #2 observed Resident #32 in bed. The call device continued to be clipped to a cord extending from the wall. It was not within Resident #32's reach.

On 08/30/2023 at 09:32 AM, Surveyor #2 observed that Resident #32's call device was not within reach. The call device was on the floor, underneath the roommate's bed.

On 09/05/2023 at 12:40 PM during an interview with Surveyor #1 and Surveyor #2, Certified Nurse Aide (CNA) #1 replied, "The policy is to answer them as soon as possible" when asked what the policy on call devices was. CNA #1 also replied, "They [call devices] should be placed by the resident if they sit in their chairs or by the bed

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F 558	Continued From page 3 if they are in bed" when asked where should call devices be placed. On 09/06/2023 at 12:53 PM, during an interview with Surveyor #2, the Licensed Nursing Home Administrator (LNHA) stated, "Within reach" when asked where should a call device be placed within a resident's room. The LNHA replied, "To call for help when they have a need" when asked by Surveyor #2 why it was important to place call device within a resident's reach. A review of the undated facility policy titled, "Call System, Resident" revealed under "Policy Interpretation and Implementation" that, "1. Each resident is provided with a means to call staff directly for assistance from his/her bed or other sleeping accommodations." 8:39-31.8(c)9	F 558		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders.	F 655		9/11/23

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F 655	Continued From page 4 (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other facility documentation, it was determined that the facility failed to develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident. The deficient practice was identified for 1 of 1 resident (Resident #271) investigated for NJ Exec Order 26 and NJ Exec Order 26.4b1 and was evidenced by the following:	F 655	Upon being made aware of the concerns on 9/6/23 the facility has previously corrected the issues regarding baseline care plan initiation for resident #271 identified in the statement of deficiencies by updating the resident care plans to reflect patient centered care. All residents had the potential to be affected by the deficient practice noted in the Statement of deficiencies (SOD).	

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F 655	Continued From page 5 A review of Resident #271's Admission Record revealed diagnoses of but not limited to; [redacted] A review of Resident #271's Care Plan revealed that there was only one care plan focus since the resident was admitted to the facility. The care plan focus was dated [redacted] and revealed that Resident #271 was at risk for [redacted] related to [redacted] and [redacted] On 09/06/2023 at 11:26 AM, during an interview with the Surveyor, Licensed Practical Nurse (LPN) #2 replied, "The baseline should be started as soon as they arrive; right after the initial assessment" when the Surveyor asked when does the facility want a baseline care plan started. When the Surveyor asked what might be included in the baseline care plan LPN #2 replied, "[redacted]." When the Surveyor asked if there was a timeframe that the facility wants the baseline care plan completed by LPN #2 replied, "I think twenty-four hours.". On the same date at 12:53 PM, during an interview with the Surveyor, the Director of Nursing replied, "Seven days" when the Surveyor asked when should a baseline care plan be completed. The Vice President of Clinical Services (VPCS) added, "A baseline care plan is generally started immediately upon arrival and within three days. [redacted], advanced	F 655	An audit was completed, no residents were found to have been negatively affected. On 9/7/23 the IDT team had an immediate extensive in person in-service provided by the Director of Nursing related to initiation of baseline care plans which included baseline care plan with 48 hours upon admission . Modifications made to daily clinical meetings to include review and establish person center care plans for all new admissions. An audit will be conducted bi-weekly by the Director of nursing/Unit Manager to ensure the modifications made to the daily clinical meeting are effective for the new admissions. The results of the audit will be reported to the monthly facility QAPI Committee for one quarter to determine if sufficient compliance has been met. Based on the results of the audit the QAPI committee will determine continued need for the audit.	

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F 655	Continued From page 6 directives, ADLs [Activities of Daily Living], risk for rehospitalization...We are trying to get to three days" when asked by the Surveyor what should a baseline care plan include. A review of an undated facility policy titled, "Care Planning-Interdisciplinary Team" revealed under "Policy Interpretation and Implementation" that, "1. Resident care plans are developed according to the timeframes and criteria established by §483.21."	F 655		
F 689 SS=D	8:39-11.2(d) Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: C/O# NJ160875 Based on observation, interviews, and record review, as well as review of facility documentation, it was determined that the facility 1.) failed to follow their policies and procedures for investigating and reporting of accidents and incidents that occur in the facility and 2.) the facility failed to ensure a resident who was a known NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1, had new or revised interventions to prevent NJ Exec Order 26.4b1.	F 689	Upon being made aware of the concerns on 9/6/23 the facility has corrected the issues regarding Incidents/Accidents stated on the Statement of deficiencies. Resident #49 Care plan was updated that patient NJ Exec Order 26.4b1 [redacted] despite attempted redirection Resident #120 Has discharged prior to identification of the deficient practice All residents had the potential to be affected by the deficient practice noted in	9/11/23

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F 689	Continued From page 7 This deficient practice occurred for 2 of 4 residents reviewed for accidents (Resident #120 and Resident #49) and was evidenced by the following: 1. The Admission Record revealed that Resident #120 was admitted to the facility with the following but not limited to diagnoses: NJ Exec Order 26.4b1 [redacted] According to the Resident Assessment Instrument Minimum Data Set (MDS), an assessment tool, Resident #120 had a staff assessed Brief Interview for Mental Status (BIMS) Score of NJ Exec Order 26.4b1 and staff assessed NJ Exec Order 26.4b1. Section E determined that Resident #120 did NJ Exec Order 26.4b1 [redacted] According to Section G of the MDS, Resident #120 required extensive assist of one person for NJ Exec Order 26.4b1 [redacted]. Section H revealed that Resident #120 was occasionally NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. A review of the Order Summary Report dated NJ Exec Order 26.4b1 revealed that resident #120 had a physician's order for the following: NJ Exec Order 26.4b1 [redacted] in the evening for NJ Exec Order 26.4b1	F 689	the Statement of Deficientcy (SOD). On 9/7/23 all nurses had an extensive in-service provided by the Director of Nursing related to incidents/accidents. Modifications have been made to daily clinical meeting to include review of all incidents/accidents, interventions, notification of family, and care plan updated with appropriate interventions. An audit will be conducted bi-weekly by the Director of nursing/Unit Manager on incidents accidents interventions as well as notification of family/Guardian and care plan updates. The results of the audit will be reported by the Director of Nursing/Unit Manager to the monthly facility QAPI Committee for one quarter to determine if sufficient compliance has been met. Based on the results of the audit the QAPI committee will determine continued need for the audit.	

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A review of the baseline care plan revealed that Resident #120 had a care plan Focus relate to, "The resident is at NJ Exec Order 26.4b1 " Date Initiated: NJ Exec Order 26.4b1. The following was observed under Goal: The resident will be NJ Exec Order 26.4b1 through the review date. Date Initiated: NJ Exec Order 26.4b1. The following was observed under the heading Interventions:

"Anticipate and meet the resident's needs." Date Initiated: NJ Exec Order 26.4b1

"Educate the resident/family/caregivers about safety reminders and what to do if NJ Exec Order 26.4b1 occurs as needed." Date Initiated NJ Exec Order 26.4b1

"Ensure that the resident is wearing appropriate footwear when ambulating/transferring as needed." Date Initiated: NJ Exec Order 26.4b1

Further review of the baseline care plan revealed that Resident #120 also had a baseline care plan with a Focus: The resident has had an NJ Exec Order 26.4b1, r/t (related to) NJ Exec Order 26.4b1. The following was listed under Interventions:

"For no apparent NJ Exec Order 26.4b1, determine and address causative factors of NJ Exec Order 26.4b1 Date Initiated: NJ Exec Order 26.4b1

"NJ Exec Order 26.4b1 consult for NJ Exec Order 26.4b1 " Date Initiated: NJ Exec Order 26.4b1

According to the Incident/Accident report, dated NJ Exec Order 26.4b1 at 04:08, NJ Exec Order 26.4b1, Resident #120 was NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 were noted, and the form indicated that "Agency/People Notified" were the physician

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at [redacted] at 04:38. There was no documentation that the family was notified of Resident #120[redacted]

The surveyor reviewed the [redacted] at 05:16 progress note in Resident #120's MR. The progress note stated, "Resident was [redacted] noted @this time, will continue to monitor." The progress note did not indicate/document that the family was notified of Resident #120[redacted].

On 09/01/2023 at 01:32 PM the surveyor reviewed the electronic medical record (EMR) of Resident #120. According to a progress note, dated [redacted] at 05:16:00, Resident #120 was [redacted] noted @this time, will continue to monitor." The progress note did not indicate that the physician or family was notified of the[redacted]. An additional progress note, dated [redacted] at 14:56:00, revealed the following: "Resident received in bed, [redacted]. Am care given by CNA. [redacted] with assist of CNA and use of walker. Daughter vss early am questioning about her [redacted] from last evening. [redacted] were reported. Vital signs this am [redacted] Daughter requesting her mom to be sent to ER for eval, supervisor aware and notified [redacted]. was contacted. Before [redacted] arrived family called 911. Resident left via 911. Vital signs [redacted]. Daughter, grandson and girlfriend accompanied resident."

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F 689	Continued From page 10 On 09/05/23 at 08:26 AM the surveyor reviewed the Reportable Event Record/Report, dated [redacted]. According to the report the reportable event concerning Resident #120 was called in on [redacted] at 12:31 PM. The reportable was called in secondary to resident daughter reporting on [redacted] that when resident [redacted] on [redacted] at approximately 12:30 AM, an unidentified nurse [redacted] and [redacted]. Family called state police and resident was sent to local emergency room at family request for evaluation. Internal investigation was completed, based on staff statements [redacted] were determined to be unsubstantiated. According to page 3 of the Reportable Event Record/Report the physician was notified and daughter was notified, however there were no dates or times listed for notification of the physician and family. 2. On 8/24/2023 at 10:38 AM, Resident #49 was observed lying in bed asleep with a [redacted] On 8/28/2023 at 12:10 PM, Resident #49 was observed lying in bed sleeping and observed [redacted] No baby dolls or stroller observed to be in room. On 9/05/2023 at 11:44 AM, Resident #49 was observed being returned to unit from activities and placed at nurses' station in w/c. According to the Admission Record, Resident # 49 was admitted to the facility with diagnoses including but not limited to: [redacted]	F 689		

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F 689	Continued From page 11 A review of a Significant change MDS dated NJ Exec Order 26.4b1, revealed a BIMS score of /15 indicating Resident #49 had NJ Exec Order 26.4b1. Section G indicated Resident #49 required extensive assist of 1 staff for NJ Exec Order 26.4b and extensive assist of 1 staff for NJ Exec Order 26.4b1 in room and on the unit. A review of a care plan with a Focus area of {resident name] has potential for NJ Exec related to NJ Exec Order 26.4b1 Walks until NJ Exec Order 26.4b1 Walks until NJ Exec Order 26.4b1 with an initiated date of NJ Exec Order 26.4b1. Under the Goal section; Resident will not NJ Exec Order 26.4b1 through the review date with an initiated dated of NJ Exec Order 26.4b1, Resident will have NJ Exec Order 26.4b1 with initiated date of NJ Exec Order 26.4b1 The resident will be NJ Exec Order 26.4b1 through the review date with an initiated date of NJ Exec Order 26.4b1 Under the intervention section Bed at acceptable height to promote staff transfers with initiated date of NJ Exec Order 26.4b1 and revision date of NJ Exec Order 26.4b1. Call light in reach, reorient prn (as needed) with initiated date of NJ Exec Order 26.4b1 and revision date NJ Exec Order 26.4b1. Encourage frequent rest periods of resident with initiated date of NJ Exec Order 26.4b1 Encourage Resident to use WC (wheelchair) for locomotion around facility with an initiated date of NJ Exec Order 26.4b1 Ensure proper fitting shoes or nonskid socks are present prior to transfer/ambulating with an initiated date of NJ Exec Order 26.4b1 and revision date of NJ Exec Order 26.4b1.	F 689		

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Ensure that resident is wearing appropriate non-skid footwear when ambulating or mobilizing w/c with an initiated date of NJ Exec Order 26.4b1 and revision date of NJ Exec Order 26.4b1. Follow NJ Ex.Order 26.4(b)(1 protocol with initiated date of NJ Exec Order 26.4b1. Frequent close monitoring throughout shift with initiated date of NJ Exec Order 26.4b1 and revision on NJ Exec Order 26.4b1. IDT team met and recommended use of NJ Exec Order and NJ Exec Order 26.4b1 family not in agreement with recommendations at this time with initiated date of NJ Exec Order 26.4b1 Maintain a clutter free environment with initiated date of NJ Exec Order 26.4b1 and revision date of NJ Exec Order 26.4b1. Offer activities that require (him/her) to sit, snacks, diversional activities etc. with initiated date of NJ Exec Order 26.4b1. Offer resident a nap after lunch with initiated date of NJ Exec Order 26.4b1. Offer resident a nap after lunch with an initiated date of NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 Evaluation Ordered with an initiated date of NJ Exec Order 26.4b1 Place frequently used items with in close reach with initiated date of NJ Exec Order 26.4b1 and revision date of NJ Exec Order 26.4b1. NJ Ex evaluate and treat as ordered or PRN with initiated date of NJ Exec Order 26.4b1 Stand by assist when patient is not utilizing NJ Exec Order 26.4b1 during ambulation with initiated date of NJ Exec Order 26.4b1 and revision date of NJ Exec Order 26.4b1. NJ Exec Order 26.4 consult prn with initiated date of NJ Exec Order 26.4b1 and revision date of NJ Exec Order 26.4b1. Verbal reminders prn to utilize the call light when assistance is needed with an initiated date of NJ Exec Order 26.4b1 and revision date of NJ Exec Order 26.4b1.

A review of NJ Exec incident dated NJ Exec Order 26.4b1 timed at 19:53 (7:53 PM), revealed "resident NJ Exec Order 26.4b1 . resident NJ Exec Order 26.4b1. Resident able to NJ Exec Order 26.4b1 or

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NJ Exec Order 26.4b1 noted. Resident stated, NJ Exec Order 26.4b1 " referring to another resident."

A review of a resolved care plan dated NJ Exec Order 26.4b1, did not include interventions or revisions to prevent further NJ Exec Ord

A review of a NJ Ex incident dated NJ Exec Order 26.4b timed at 23:55 (11:55 PM), revealed "Heard noise Went to room and saw resident NJ Exec Order 26.4b1 between his/her bed and chair NJ Exec Order 26.4b1 Resident NJ Exec Order 26.4b1 . Resident stated he/she NJ Exec Order 26.4b1

A review of a resolved care plan dated NJ Exec Order 26.4b1, did not include new interventions or revision to prevent further NJ Exec O

A review of a NJ Exec O dated NJ Exec Order 26.4b1 timed at 05:10 (05:10 AM), revealed " Patient was NJ Exec Order 26.4b1 When trying to redirect pt (patient) to lay down, pt continued to NJ Exec Order 26.4b1 . Nurse on NJ Exec Order 26.4b called and stating Pt NJ Exec Order 26.4b1." Under resident description "I don't know."

A review of a resolved care plan dated NJ Exec Order 26.4b1 did not include new interventions or revisions to prevent further NJ Exec O

A review of a NJ Exec dated NJ Exec Order 26.4b1 timed at 18:58 (6:58 PM), revealed CNA called me to NJ Exec Order at nursing station and stated [resident name] tried to NJ Exec Order 26.4b1

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F 689	Continued From page 14 A review of a resolved care plan did not include new interventions or revisions to prevent further [redacted] A review of a [redacted] dated [redacted] timed at 19:53 (7:53 PM) revealed "called to [redacted] to observed resident [redacted] A review of a resolved care plan dated [redacted] did not include new interventions or revisions to prevent further [redacted]. A review of a [redacted] date [redacted] timed at 15:33 (3:33 PM) revealed " [redacted] A review of a resolved care plan dated [redacted] did not include new interventions or revisions to prevent further [redacted] A review of a [redacted] dated [redacted] timed at 14:55 (2:55 PM), revealed "[resident name] [redacted] " A review of a care plan with an initiated dated of [redacted], did not include new interventions or revisions to prevent further [redacted] A review of a [redacted] dated [redacted] timed at 05:05 (05:05 AM), revealed '[redacted]. [redacted] at this time. Resident unable to give description." A review of a care plan with an initiated dated of [redacted], did not include new interventions or	F 689		

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F 689	Continued From page 15 revisions to prevent further [NJ Exec O] A review of a [NJ Exec O] dated [NJ Exec Order 26.4b1] timed at 05:25 AM, revealed Resident [NJ Exec Order 26.4b1] [redacted], [NJ Exec Order 26.4b1] at this time. Resident [NJ Exec Order 26.4b1] noted. A review of a care plan with an initiated dated of [NJ Exec Order 26.4b1], did not include new interventions or revisions to prevent further [NJ Exec O]. A review of a [NJ Exec O] dated [NJ Exec Order 26.4b1] timed at 05:18 (05:18 AM), revealed resident [NJ Exec Order 26.4b1] [redacted] bed in lowest position. [NJ Exe] [redacted] at this time. A review of a care plan with an initiated dated of [NJ Exec Order 26.4b1], did not include new interventions or revisions to prevent further [NJ Exec O]. During an interview with the surveyor on 9/05/2023 at 11:10 AM, CNA #2 who said If someone [NJ Exec O] I get the nurse and let the nurse know. They evaluate the resident and let us know what we do next. We have to write a statement and make sure our statement goes to Director of Nursing before the end of the shift Duirng an interview with the surveyor on 9/5/2023 at 10:54 AM, Licensed Practical Nurse (LPN #1) was asked what the facility policy was for what is done after a [NJ Exec Order 26.4b1] LPN #1 responded, If someone [NJ Exec O] the Certified Nursing Assistant (CNA) calls the nurse immediately and if a Licensed Practical Nurse (LPN) is there we (LPN) can't touch them. We get the Registered Nurse (RN) to come over and do an assessment and they will determine if we can move the resident after a full body assessment. Then we get them	F 689		

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up and call the MD and family and get treatments, if needed. We put them on the 24-hour report for 3 full days every shift. We conduct full vitals and nurses notes in the EMR. We do incident report as well and document the incident in the progress notes in the EMR. We gather statements from anyone on duty that shift even though they may not have been assigned to that resident on that shift. We staple the witness statements to the incident report, and we hand it off to the Director of Nursing.

During an interview ith the surveyor on 9/5/2023 at 11:31 AM, the Unit Manager/Licensed Practical Nurse (UM/LPN) was asked what the facility process after a resident is after a resident NJ Exec Order 26.4b1 NJ Exec O The UM/LPN responded, If someone I immediately keep them safe and notify my direct supervisor. I do an assessment. The assessment can be done by an RN or LPN. We do a full body assessment for range of motion, neurological checks and check for any injuries and complete vital signs. The surveyor asked the UM/LPN where this information should be documented. The UM/LPN replied, It would be documented in risk management (incident and accident reports). I always document in risk management and then copy and paste into a nurse's progress note. I notify the physician and the family and write that on the incident report, and I put my note in risk management. UM/LPN went on to sat that regardless of if resident sat self on floor or fell, we need to do incident report. If resident unable to tell us what happened, I ask staff when resident was last time was seen and what was the resident doing. Staff do write paper statements and there is a section we can type them in as well on the incident report.
When asked is the care plan reviewed or updated

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F 689	Continued From page 17 UM/LPN replied I would look and see what interventions are on the care plan and if needs to be tweaked and add any new interventions. You should have a new intervention. If we are doing what is on the care plan, then something needs to be adjusted. Absolutely a care plan is to be updated after a[NJ Exec O] On 9/6/2023 at 1:02 PM, the surveyor conducted an interview with facility administration including the Director of Nursing (DON), the Vice President of Clinical Services (VPCS) and the Licensed Nursing Home Administrator. The surveyor asked the administrative staff what their expectation was when an accident or incident occurs in the facility? Who is to be notified and when should they be notified? The VPCS stated, " The resident would be assessed, vitals checked, neuro checks, and notification of the family and MD." The surveyor questioned what the expected time frame would be after the incident occurred to notify the family and physician of the incident. The VPCS replied, "The time frame would be as soon as possible, but my expectation is within a few hours regardless of what time the incident occurred." The surveyor then asked the VPCS if she would have expected that the family of Resident #120 should have been notified of Resident #120's[NJ Exec] prior to arriving to the facility approximately 12 hours after[NJ Exec Order 26] The VPCS responded, "I would have expected the family to be notified prior to them arriving to the facility approximately 12 hours later and being told by the resident." When the surveyor asked the DON what her expectation was for a resident who has had [NJ Exec Order 26.4b1] she replied they ([NJ Exec Order 26.4b1]) are reviewed by Interdisciplinary team and MD part of plan of correction, and interventions are to	F 689		

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be put in place. Yes, there should be documentation of revision or new interventions on the care plan after each fall.
The DON also said that the DON, UM are responsible to update the care plans after falls. VPCS added that the floor nurses can as well (update care plan).

The surveyor reviewed a facility policy titled Accidents and Incidents-Investigating and Reporting, last updated 4/2023. The Policy Statement revealed the following:

"All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the administrator."

The following was revealed under the heading Policy Interpretation and Implementation:

1. The nurse supervisor/charge nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident.

2. The following data, as applicable, shell be included on the Report of Incident/Accident form:

g. The time the injured person's attending physician was notified, as well as the time the physician responded and his/her instructions.

h. The date/time the injured person's family was notified and by whom.

A review of a facility policy titled Falls-Clinical Protocol undated revealed under Cause

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F 689	Continued From page 19 Identification section 1. For an individual who has fallen, the staff and practitioner will begin to try identifying possible causes within 24 hours of the fall. A further review of the policy under the treatment/Management section 1. based on preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. Under the Monitoring and Follow-up section 4. If the individual continues to fall, the staff and physician will re-evaluate the situation and reconsider possible reasons for the resident's falling (instead of, or in addition to those that have already been identified) and also reconsider the current interventions. NJAC 8:39-27.1(a)	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documents, it was determined that the facility failed to follow professional standards of practice by providing a NJ Exec Order 26.4b1 without physician's order for 1 of 3 residents (Resident #320) reviewed for	F 695	Upon being made aware of the concerns on 9/6/23, the facility has previously corrected the issue regarding proper use of NJ Exec Order 26.4b1 with a physician order. All residents requiring respiratory care had the potential to be affected by deficient	9/11/23

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F 695	Continued From page 20 NJ Exec Order 26.4b1 Care. This deficient practice was evidenced by the following: On 08/28/2023 at 11:01 AM, the surveyor observed a NJ Exec Order 26.4b1 in Resident #320's room. The NJ Exec Order 26.4b1 on top of the NJ Exec Order 26.4b1 The NJ Exec Order was exposed to the environment. At that time, Resident #320 stated, "I have been using it NJ Exec Order 26 every night" when asked by the Surveyor if he was using the NJ Exec Order device. On 08/29/2023 at 08:47 AM, the surveyor observed the NJ Exec Order 26.4b1 on top of the NJ Exec Order The NJ Exec Order appeared to have NJ Exec Order 26.4b1 . During that time, Resident #320 added, "I have been using the NJ Exec Order every night since I got here." A review of Admission Record found in Electronic Medical Record (EMR) revealed that Resident #320 was admitted to the facility on NJ Exec Order 26.4b1 with diagnoses including, but not limited to: NJ Exec Order 26.4b1 A review of Resident #320's Admission Minimum Data Set (MDS; an assessment tool) dated NJ Exec Order 26.4b1 revealed that Resident #320 had a Brief Interview for Mental Status (BIMS) score of NJ Ex /15 indicating NJ Exec Order 26.4b1 . A review of EMR revealed no physician's orders for NJ Exec Order 26.4b1 nor settings.	F 695	practice noted in Statement of Deficiency. An audit was completed, and no residents were found to have been negatively affected. Resident #320 was deemed not negatively affected by the deficient practice as evidence by vital signs were monitored and showed no change in NJ Exec Order 26.4b1 . Resident #320 made no reports of NJ Exec Order 26.4b1 Laboratory trends from NJ Exec Order 26 and NJ Exec Order 26 indicated an improvement in NJ Exec Order 26.4b1 related to the previously diagnosed NJ Exec Order 26.4b1 . Nurse Practitioner completed a physician assessment on NJ Exec Order 26 noting NJ Exec Order 26.4b1 in conditions. On 9/7/23 all nurses had an extensive in-service provided by the Director of Nursing related to the need for physician order to provide respiratory care, even in the event respiratory equipment is brought with resident from home. Modifications have been made to daily clinical meeting to include review of new admissions who may require physician orders for patients requiring respiratory care. The Director of nursing/Unit Manager will conduct weekly audits. The results of the audit will be reported by the director of nursing/Unit Manager to the monthly facility QAPI Committee for one quarter to determine if sufficient compliance has been met. Based on the results of the audit the QAPI committee will determine continued need for the audit.	

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F 695	Continued From page 21 A review of Progress Notes revealed "Nursing Note" dated [NJ Exec Order 26.4b1] at 11:14 PM which indicated " ... He is currently in bed with [NJ Exec Orde] running per orders ..." On 09/06/2023 at 11:33 AM, during an interview with the surveyor, Licensed Practical Nurse (LPN #3) stated, "No, we have to have a doctor's order" when asked if doctor's order is needed to administer [NJ Exec Order 26.4b1] such as [NJ Exec Orde]. On 09/06/2023 at 12:56 PM, during an interview with the surveyor, the Vice President of Clinical Services (VPSC) stated, "Absolutely!" when asked if a [NJ Exec Order 26.4b1] requires physician's order. A review of a facility policy updated 04/2023 and titled "Medication and Treatment Orders" revealed that "Orders for medications and treatments will be consistent with principles of safe and effective order writing. 1. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state." A review of an undated facility policy titled "CPAP/BiPAP Support" revealed, "3. Review physician's order to determine the oxygen concentration and flow, and PEEP pressure (CAPA, IPAP, and EPAP) for the machine." NJAC 8:39-44.2(b)(2)	F 695		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who	F 698		9/15/23

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F 698	Continued From page 22 require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the medical record and review of other facility documentation, it was determined that the facility failed to ensure a resident's medication times were adjusted to accommodate their [NJ Exec Order 26] schedule for 1 of 1 resident (Resident #28) reviewed for [NJ Exec Order 26] This deficient practice was evidenced by the following: On 08/23/2023 at 9:40 AM, Resident #28 was observed sitting in a wheelchair getting items out of his/her closet. Resident #28 said he/she goes to [NJ Exec Order 26] on Monday, Wednesday, and Friday. Resident #28 stated that he/she usually back to the facility by "lunch time." A review of the Electronic Medical Record revealed Resident #28 was admitted to the facility with diagnoses including but not limited to, [NJ Exec Orde] [redacted] A review of the most recent Minimum Data Set (MDS), an assessment tool used to facilitate care, dated [NJ Exec Order 26.4b1], revealed a Brief Interview for Mental Status score of [redacted]/15, indicating Resident #28 was [NJ Exec Order 26.4b1]. The MDS further revealed Resident #28 received [NJ Exec Order 26] while a resident at the facility.	F 698	Upon being made aware of the concerns on 9/6/23, the facility immediately corrected the issue regarding proper plotting of medication administration times for [NJ Exec Order 26] patients. Resident #28 identified in the SOD was at no point negatively affected by deficient practice. All residents requiring out of facility dialysis treatment had the potential to be affected by deficient practice noted in SOD. An audit was completed, and no residents were found to have been negatively affected. On 9/6/23 all nurses had an extensive in-service provided by the Director of Nursing related to the proper plotting of medication administration times for patients requiring out of facility dialysis treatments. IDT team to perform weekly audits review dialysis chair time schedule for upcoming week to identify any changes in normal schedule and plot medication administration according to all variations of regular schedule. The results of the audits will be reported to the facility monthly QAPI committee meeting for one quarter by the Director of Nursing to determine if sufficient compliance has been met. Based on the results of the audit the QAPI committee will determine continued need for the audit.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315014	A. BUILDING _____ B. WING _____	C 09/07/2023

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BIG OAK REHABILITATION AND HEALTHCARE CENTER	849 BIG OAK ROAD PITTSGROVE, NJ 08318

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F 698	Continued From page 23	F 698		

A review of the Clinical Physicians Orders revealed a physician order for NJ Exec Order 26.4b1, per physician order:

-NJ Exec Order 26.4b1 three times weekly on Monday/Wednesday/Fridays, Chair time 5:30 AM.

A further review of the physician orders revealed the following orders:

-NJ Exec Order 26.4b1 three times a day every Mon, Wed, Fri for NJ Exec Order 26.4b1 days 11:30

NJ Exec Order 26.4b1 Give 1 tablet orally one time a day for NJ Exec Order 26.4b1 09:00 AM

-NJ Exec Order 26.4b1 Give 1 tablet orally one time a day 09:00 AM

-NJ Exec Order 26.4b1 Give 1 tablet orally two times a day for NJ Exec C 09:00 AM

-NJ Exec Order 26.4b1 Give 1 tablet orally one time a day for NJ Exec Order 26.4b1 09:00 AM

NJ Exec Order 26.4b1 four times a day for NJ Exec Order 26.4b1 09:00 AM

-NJ Exec Order 26.4b1 via NJ Exec Order 26.4b1 two times a day for NJ Exec Order 2 09:00 AM

-NJ Exec Order 26.4b1 Give 1 tablet orally

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every 12
hours for [redacted] 09:00 AM

-[redacted] Give 1 capsule orally one
time a day for [redacted] 09:00 AM

-[redacted]
three times a day every Mon, Wed, Fri for [redacted]

Call MD if [redacted] four times a day every Mon, Wed, Fri.
09:00-14:00-21:00

A review of the "Medication Audit Report" for [redacted] revealed:

[redacted] was administered on the following dates and times:

[redacted] scheduled for 09:00 AM and given at 10:57 AM
[redacted] scheduled for 09:00 AM and given at 11:35 AM
[redacted] scheduled for 09:00 AM and given at 10:45 AM
[redacted] scheduled for 09:00 AM and given at 11:12 AM
[redacted] scheduled for 09:00 AM and given at 11:22 AM

[redacted] Tablet was administered on the following dates and times:

[redacted] scheduled for 09:00 AM and given at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 698	Continued From page 25	F 698		

10:57 AM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 10:45 AM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 11:12 AM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 11:22 AM

NJ Exec Order 26.4b1 was administered on the following dates and times:

NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 11:02 AM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 11:35 AM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 10:45 AM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 11:12 AM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 11:22 AM``

NJ Exec Order 26.4b1 was administered on the following dates and times:

NJ Exec Order 26.4b1 scheduled for 11:30 AM and given at 14:18 PM

NJ Exec Order 26.4b1 was administered on the following dates and times:

NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 11:35 AM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 10:45 AM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 11:22 AM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 698	Continued From page 26	F 698		

NJ Exec Order 26.4b1 was administered on the following dates and times:

NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 11:34 AM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 10:45 AM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 11:12 AM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 11:22 AM

NJ Exec Order 26.4b1 was administered on the following dates and times:

NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 11:35 AM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 10:45 AM

A review of the "Medication Audit Report" for NJ Exec [redacted] revealed:

NJ Exec Order 26.4b1 was administered on the following dates and times:

NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 10:19 AM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 12:37 PM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 10:30 AM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 10:31 AM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 10:58 AM

NJ Exec Order 26.4b1 was administered on the following dates and times:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 698	Continued From page 27	F 698		

[redacted] scheduled for 09:00 AM and given at 10:19 AM
[redacted] scheduled for 09:00 AM and given at 12:42 PM
[redacted] scheduled for 09:00 AM and given at 10:30 AM
[redacted] scheduled for 09:00 AM and given at 10:31 AM
[redacted] scheduled for 09:00 AM and given at 10:58 AM

[redacted] was administered on the following dates and times:

[redacted] scheduled for 09:00 AM and given at 10:19 AM
[redacted] scheduled for 09:00 AM and given at 12:42 PM
[redacted] scheduled for 09:00 AM and given at 10:30 AM
[redacted] scheduled for 09:00 AM and given at 10:31 AM
[redacted] scheduled for 09:00 AM and given at 10:58 AM

[redacted] was administered on the following dates and times:

[redacted] scheduled for 09:00 AM and given at 10:19 AM
[redacted] scheduled for 09:00 AM and given at 12:42 PM
[redacted] scheduled for 09:00 AM and given at 10:30 AM
[redacted] scheduled for 09:00 AM and given at 10:31 AM
[redacted] scheduled for 09:00 AM and given at 10:58 AM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 698	Continued From page 28	F 698		

NJ Exec Order 26.4b1 was administered on the following dates and times:

NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 12:50 PM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 12:43 PM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 10:43 AM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 10:31 AM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 10:58 AM

NJ Exec Order 26.4b1 was administered on the following dates and times:

NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 10:19 AM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 12:42 PM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 10:30 AM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 10:31 AM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 10:58 AM

NJ Exec Order 26.4b1 was administered on the following dates and times:

NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 10:19 AM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 12:42 PM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 10:30 AM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 698	Continued From page 29	F 698		

NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 10:31 AM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 10:58 AM

A review of the "Medication Audit Report" for NJ Exec Order 26.4b1 revealed:

NJ Exec Order 26.4b1 was administered on the following dates and times:

NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 12:07 PM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 10:10 AM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 12:47 PM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 10:58 AM

NJ Exec Order 26.4b1 was administered on the following dates and times:

NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 12:07 PM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 10:10 AM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 12:47 PM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 10:58 AM

NJ Exec Order 26.4b1 was administered on the following dates and times:

NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 12:07 PM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 10:10 AM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 698	Continued From page 30	F 698		

NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 12:47 PM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 10:58 AM

NJ Exec Order 26.4b1 was administered on the following dates and times:

NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 12:07 PM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 10:10 AM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 12:47 PM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 10:58 AM

NJ Exec Order 26.4b1 was administered on the following dates and times:

NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 12:07 PM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 10:10 AM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 12:47 PM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 10:58 AM

NJ Exec Order 26.4b1 was administered on the following dates and times:

NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 12:07 PM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 10:10 AM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at 12:47 PM
NJ Exec Order 26.4b1 scheduled for 09:00 AM and given at

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F 698	Continued From page 31 10:58 AM During an interview with the surveyor on 09/05/202 at 11:22 AM, the Licensed Practical Nurse (LPN) #4, on the same unit as Resident #28 stated; "All medications are to be given no earlier or later than 1 hour before and 1 hour after the scheduled time. If my resident is unavailable or sleeping, I will call the doctor and report and see if he wants to reschedule the medication time. I will also write a nursing note to explain the situation. If I have a resident that is out of the building consistently, such as for [NJ Exec Order 26], I will call the doctor to have the medications re-plotted according to their pickup and return to the facility time." During an interview with the surveyor on 09/06/2023 at 12:53 PM, the Director of Nursing stated that residents on [NJ Exec Order 26.4b1] should have their medications plotted around the time that the resident is out of the building. It is the responsibility of all nursing staff to monitor times and assure that medications are schedule appropriately. A review of a facility policy titled, "Administering Medications," with a date of 04/2023, revealed the following: #4 Medications are administered within one (1) hour of their prescribed time, unless otherwise specified." A review of a facility policy title, "Dialysis Communication," did not address the medication and treatment times.	F 698		

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F 698	Continued From page 32 NJAC 8:39-27.1(a)	F 698		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in	F 756		9/21/23

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F 756	Continued From page 33 the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review and review of other facility documentation, it was determined that the facility failed to address the recommendations made by the Consultant Pharmacist (CP) in a timely manner. This deficient practice was identified for 4 of 5 resident's reviewed for unnecessary medications (Resident #61, Resident #1, Resident #3, and Resident #27), and was evidenced by the following: On 8/29/2023 at 10:42 AM, the Surveyor #1 reviewed the medical records for Resident #61. According to the Admission Record, Resident #61 was admitted to the facility with the following but not limited to diagnoses: NJ Exec Order 26.4b1 [redacted] According to the quarterly Resident Assessment Instrument Minimum Data Set (MD'S), an assessment tool, dated NJ Exec Order 26.4b1, Resident #61 had a Brief Interview for Mental Status score of NJ E/15, indicating NJ Exec Order 26.4b1. Section MN revealed that Resident #61 received NJ Exec Order 26.4b1 daily, an NJ Exec Order 26.4b1 daily, and NJ Exec Order 26.4b1 daily. On NJ Exec Order 26.4b1 the CP suggested "Please clarify the NJ Exec Order 26.4b1 orders. The nighttime order still states to apply but also remove. Contradicting. Update nighttime order directions." Facility responded on NJ Exec Order 26.4b with changing the nighttime order to read:	F 756	Upon being made aware of the concerns on 9/6/23, the facility had previously identified the deficient practice noted in SOD regarding drug regimen review. A new pharmacy consulting company was hired at the time this deficient practice was identified. Residents #61, #1, #3, and #27 were all seen by physician and medication review completed, no concerns noted. All residents of the facility have had the potential to be affected by the deficient practice noted in the SOD. An audit was completed, no residents were found to have been negatively affected. On 9/7/23, modifications were made to the daily clinical meeting to include review new drug regimen reviews provided by pharmacy consultant. An audit will be conducted bi-weekly to ensure the modifications made to the daily clinical meeting are effective. The results of the audit will be reported to the monthly facility QAPI Committee for one quarter to determine if sufficient compliance has been met. Based on the results of the audit the QAPI committee will determine continued need for the audit. Compliance date: 9/21/2023	

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F 756	Continued From page 34 NJ Exec Order 26.4b1 (every) hs (night) in the evening -Start Date NJ Exec Order 26.4b1 2100 -D/C Date NJ Exec Order 26.4b1 1337 On NJ Exec Order 26.4b1: The CP recommended "Please chart a NJ Exec Order 26.4b1 for the NJ Exec Order 26.4b1 3x (times) daily order. Currently not shown on MAR." The facility failed to respond to CP suggestion until NJ Exec Order 26.4b1. Review of the NJ Exec Order 26.4b1 MAR revealed that NJ Exec Order 26.4b1 were not recorded on the MAR from NJ Exec Order 26.4b1 through NJ Exec Order 26.4b1 at 0800, 1130, and 1630. On NJ Exec Order 26.4b1 the CP suggested, "Identify and monitor the behavior being exhibited for NJ Exec Order 2 and other NJ Exec Order 26.4b1. NJ Ex.Order 26.4(b)(order not entered into PCC." Facility responded on NJ Exec Order 26.4b1 with the following order: NJ Ex.Order 26.4(b)(1) FOR THE FOLLOWING: () NJ Exec Order 26.4b1 Document: 'N' if none of the above observed. 'Y' if any of the above was observed, select chart code 'Other/ See Nurses Notes' and progress note findings. every shift -Start Date NJ Exec Order 26.4b1 1500	F 756		

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	315014	A. BUILDING _____ B. WING _____	C 09/07/2023

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F 756	Continued From page 35 The facility failed to respond for approximately 90 plus days. On NJ Exec Order 26.4b1 the CP made the following recommendations/suggestions: "Regarding the comment made on NJ Exec Order 26.4b1: Please clarify the NJ Exec Order 26.4b1 orders. The nighttime order still states to apply but also remove. Contradicting. Update nighttime order directions. **The Pharmacy Consult was not addressed." The facility did not respond until NJ Exec Order 26.4b1 by discontinuing al NJ Exec Order 26.4b1, approximately 4 months later. "Regarding the comment made on NJ Exec Order 26.4b1: Please chart a NJ Exec Order 26.4b1 for the NJ Exec Order 26.4b1 3x daily order. Currently not shown on MAR. *The Pharmacy Consult was not addressed. NJ Exec Order 26.4b1 already being documented with the NJ Exec Order 26.4b1 order. Other NJ Exec Order 26.4b1 order is extra." The facility failed to respond to the CP recommendation until NJ Exec Order 26.4b1 through 0900, approximately 90 days after the original suggestion. On NJ Exec Order 26.4b1 the CP made the following recommendation/suggestion: "Regarding the comment made on NJ Exec Order 26.4b1: Please chart a NJ Exec Order 26.4b1 for the NJ Exec Order 26.4b k 3x daily order. Currently not shown on MAR. *The Pharmacy Consult was not addressed. NJ Exec Order 26.4b1 already being documented with the NJ Exec Order 26.4b1 order. Other NJ Exec Order 26.4b1 order is extra." The facility responded on NJ Exec Order 26.4b1 at 0949 b y discontinuing the NJ Exec Order 26.4b1, approximately 60 plus days after the	F 756		

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F 756	Continued From page 36 CP suggested. 2. According to the Admission Record, Resident #1 was admitted to the facility with diagnoses including but not limited to: NJ Exec Order 26.4b1 [redacted] A review of the Consultant Pharmacist Monthly report dated NJ Exec Order 26.4b1 indicated "Identify and monitor the behavior being exhibited for NJ Exec Order 2 [redacted]. Please add the orders to monitor for side effects and behaviors in [name of electronic medical record]." A review of the Order Summary Report with Active orders as of NJ Exec Order 26.4b1 through and including NJ Exec Order 26.4b1 did not include a physician order to add Identify and NJ Ex.Order 26.4(b)(1) [redacted] exhibited for NJ Exec Order 2. There was no documentation that the CP recommendations were addressed. 3. According to the Admission Record, Resident #3 admitted with diagnoses including but not limited to: NJ Exec Order 26.4b1 [redacted] and NJ Exec Order 26.4b1 [redacted] A review of a CP report dated NJ Exec Order 2 which indicated "regarding the comment made on NJ Exec Order 26.4b1 Please clarify and updated the diagnosis for NJ Exec Order 26.4b1. Not indicated for NJ Exec Order 26.4b1. Only indication is NJ Exec Order 2. Verify with Physician. *The Pharmacy Consult was not	F 756		

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F 756	Continued From page 37 addressed." A review of the OSR with active orders as of NJ Exec Order 26.4b1 revealed a physician order for NJ Exec Order 26.4b1 give 1 tablet orally two times a day for NJ Exec Order 26.4b1. A review of the OSR with active orders as of NJ Exec Order 26.4b1 through NJ Exec Order 26.4b1 indicated the same physician order for the NJ Exec Order 26.4b1 give 1 tablet orally twice a day for NJ Exec Order 26.4b1. A review of the CP report for NJ Exec Order 26.4b1 indicated with date of NJ Exec Order 26.4b1 "Regarding the comment made on NJ Exec Order 26.4b1: Please update the indication for PRN (as needed) NJ Exec Order 26.4b1 NJ Exec Order is a diagnosis, not an indication. Consider using NJ Exec O or NJ Exec Order 26.4b1. The Pharmacy Consult was not addressed." A review of the OSR with active orders as of NJ Exec Order 26.4b1 through NJ Exec Order 26.4b1 revealed a physician order for NJ Exec Order 26.4b1 6 hours as needed for NJ Exec Order 2 There was no documentation in the medical record that the CP recommendations were addressed. 4. According to the Admission Record, Resident #27 was admitted to the facility with diagnoses including but not limited to: NJ Exec Order 26.4b1	F 756		

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F 756	Continued From page 38	F 756		

A review of a CP report for [redacted] revealed a recommendation dated [redacted] to clarify if the order for [redacted] is for [redacted] or [redacted]

A review of the OSR dated [redacted], revealed [redacted] Give 1 tablet by mouth one time a day for [redacted]

A further review of the CP report revealed a recommendation dated [redacted] "There are PRN (as needed) orders with the same or overlapping indications for use. Please sequence or differentiate the indications for [redacted] "

A review of the OSR dated [redacted] indicated [redacted] *Controlled Drug* with original order date of [redacted] Give [redacted] tablet by mouth every 4 hours as needed for [redacted]

A further review of the OSR revealed a physician order for [redacted] with order date [redacted] Give 2 tablet by mouth every 4 hours as needed for [redacted]

There was no documentation in the medical record to indicate the CP recommendations were addressed.

On 9/6/2023 at 1:13 PM, the surveyors conducted an interview with the Vice President of Clinical Services (VPCS). The surveyors asked the VPCS what the facility process was for responding to

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F 756	Continued From page 39 the CP monthly report for medication recommendations/suggestions. The VPCS explained, "Within a day or 2 we get a report that is received by the facility Director of Nursing and Unit Managers (UM). The DON and Unit Manager would be responsible for responding to the suggestions/recommendations within 30 days once we receive the monthly report from the CP. We identified that it was a problem, and we are addressing it at this time." A review of a facility policy titled Medication Regimen Reviews last updated 4/2023, which revealed under the Policy Interpretation and Implementation section 8. Within 72 hours of the MRR, the consultant pharmacist provides a written report to the attending physicians and for each resident identified as having a non life threatening medication irregularity. A further review revealed 14. The Consultant Pharmacist provides the director of nursing services and medical director with a written, signed and dated copy of all medication regimen reports. Follow up will be completed within 30 days.	F 756		
F 880 SS=E	NJAC 8:39-29.3(a)(1) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		9/20/23

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F 880	Continued From page 40	F 880		

program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct

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F 880	Continued From page 41 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to use appropriate precautions to disinfect and store NJ Exec Order 26.4b1 equipment to prevent the risk of infections. The deficient practice was observed in 3 of 3 residents (Resident #320, Resident #1, and Resident #3) reviewed for NJ Exec Order 26.4b1 Care. This deficient practice was evidenced by the following: 1.) On 08/24/2023 at 10:03 AM, Surveyor #1 observed a NJ Exec Order 26.4b1 device on Resident #320's nightstand with a NJ Exec Order 26.4b1 on top of the device. The NJ Exec O was exposed to the environment. The NJ Exec Ord appeared to have NJ Exec Order 26.4b1 from within. On 08/28/2023 at 11:01 AM, Surveyor #1	F 880	Upon being made aware of the concerns on 9/6/23, the facility corrected all issues to ensure the facility uses appropriate precautions to disinfect and store NJ Exec Order 26.4b1 equipment. Resident #320, Resident #1, and Resident #3 identified in the Statement of deficiencies (SOD) were immediately assessed for changes in NJ Exec Order 26.4b1. All residents requiring respiratory care had the potential to be affected by deficient practice noted in Statement of deficiencies (SOD). An audit was completed, and no residents were found to have been negatively affected. On 9/6/23 the entire staff had an immediate extensive in-service provided by the Director of Nursing related to disinfection and storage of respiratory equipment. The DON/designee will conduct bi-weekly audits for three weeks,	

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F 880	Continued From page 42 observed Resident #320's NJ Exec Order 26.4b1 on top of the device. It was exposed to the environment and continued to appear to have NJ Exec Order 26.4b1 inside. At that time, Surveyor #1 asked Resident #320 if he/she was using the NJ Exec Order 26.4b1. Resident #320 stated, "I have been using it NJ Exec Order 26 every night." On 08/29/2023 at 08:47 AM, Surveyor #1 observed NJ Exec Order 26.4b1 on top of the NJ Exec Order 2 and exposed to the environment. At that time, Resident #320 stated, "I have been using the NJ Exec Order 2 every night since I got here." When asked by Surveyor #2 if staff cleans his/hers NJ Exec Order 26.4b1 Resident #320 replied, "Not yet, but they will clean it today." On 08/30/2023 at 09:30 AM, Surveyor #2 observed NJ Exec Order 26.4b1 on top of the device. The mask continued to be exposed to the environment. NJ Exec Order 26.4b1 appeared to be inside of the mask. A review of Admission Record revealed that the Resident had diagnosis of NJ Exec Order 26.4b1 A review of Resident #320's Admission Minimum Data Set (MDS; an assessment tool) dated NJ Exec Order 26.4b1 revealed that Resident #320 had a Brief Interview for Mental Status (BIMS) score of NJ Ex/15 indicating that his/her NJ Exec Order 26.4b1 2. During the initial tour on 8/24/2023 at 10:55 AM, Surveyor #2 observed Resident # 1 NJ Exec Order 26.4b1 in a bed side chair uncovered and exposed.	F 880	weekly for three weeks, and monthly thereafter. The results of the audits will be reported to the facility monthly QAPI committee meeting by the Director of Nursing/Infection prevention nurse for one quarter to determine if sufficient compliance has been met. Based on the results of the audit the QAPI committee will determine continued need for the audit. Compliance date 9/20/23.	

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F 880	Continued From page 43 On 8/28/2023 at 10:09 AM, Surveyor #2 observed Resident #1's NJ Exec Order 26.4b1 on the bedside table. The NJ Exec Order 26.4b1 was sitting on top of the machine uncovered and exposed. The NJ Exec Order was dated NJ Exec Or On 8/29/2023 at 10:30 AM, Surveyor #2 observed Resident #1's NJ Exec Order 26.4b1 on the bedside table with the NJ Exec Order 26.4b1 sitting on top, uncovered and exposed NJ Exec Order 26.4b1. According to the Admission Record Resident #1 was admitted to the facility with diagnoses including but not limited to: NJ Exec Order 26.4b1 A review of the MDS dated NJ Exec Order 26.4b1 revealed Resident #1 had a BIMS score of NJ Ex/15 indicating Resident #1 was NJ Exec Order 26.4b1. A further review revealed under section O Resident #1 received 5 days of NJ Exec Order 26.4b1. A review of the Order Summary Report (OSR) with active orders as of NJ Exec Order 26.4b1 revealed a physician order for NJ Exec Order 26.4b1 orally every 6 hours as needed for NJ Exec Order 26.4b1 A review of the Medication Administration Record (MAR) for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 revealed Resident #1 received a NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 There is no indication in the medical record as to when the NJ Exec Order 26.4b1 is to be changed.	F 880		

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During an interview with the Surveyor #2 on 8/28/2023 at 10:06 AM, when asked if staff cover the NJ Exec Order 26.4b1 or change the NJ Exec Order on the NJ Exec Order 26.4b1 Resident #1 replied "no staff never cover NJ Exec Order 26.4b1 no don't change the NJ Exec Orde." Resident #1 said he/she used 1 time in the past month.

3. During the initial tour on 08/24/23 10:16 AM, observed NJ Exec Order 26.4b1 in a basin next to a NJ Exec Order 26.4b1 uncovered and exposed.

On 8/28/2023 at 10:01 AM, Surveyor #2 observed Resident #3's NJ Exec Order 26.4b1 in basin on bedside table. During an interview with Resident #3 at that time, Resident #3 said he/she is not able to place his/her NJ Exec Order 26.4b1 in the basin and that staff takes it off and places it on for him/her.

On 8/29/2023 at 10:28 AM, Surveyor #2 observed Resident #3's NJ Exec Order 26.4b1 on top of bath towel in a basin on bedside table.

According to the Admission Record Resident #3 was admitted to the facility with diagnoses including but not limited to: NJ Exec Order 26.4b1

A review of an MDS dated NJ Exec Order 26.4b1 revealed Resident #3 had a BIMS score NJ E/15, indicating Resident #3 had NJ Exec Order 26.4b1 .

A review of OSR revealed physician orders as follows;
NJ Exec Order 26.4b1
& remove on day shift at bedtime apply

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NJ Exec Order 26.4b1 NJ Exec Order 26.4b1) & remove on day shift every day shift Remove NJ Exec Order on day shift. NJ Exec Order 26.4b1 with warm water and let dry Q (every) Friday on 7-3 shift.

On 08/30/2023 at 10:50 AM during an interview with Surveyor #1 attended by Vice President of Clinical Services (VPCS) and Unit Manager/Licensed Practical Nurse (UM/LPN), the VPCS replied, "Rentals go back. Owned equipment is cleaned and stored in plastic bags. If used by resident, they should be bagged and dated" when asked about facility's procedure for NJ Exec Order 26.4b1 equipment storage.

During the same interview, both VPCS and UM/LPN replied, "No" when asked by Surveyor #1 if it was acceptable to store NJ Exec Order or NJ Exec Order 26.4b not in a plastic bag. Further, the UM/LPN stated, "It is a potential for airborne infections" when Surveyor #1 asked why it was unacceptable to not contain the NJ Exec Order 26.4b1 in a plastic bag.

During an interview with surveyor #2 on 9/05/2023 at 10:58 AM, Licensed Practical Nurse (LPN #1) was asked how NJ Exec Order 26.4b1 is stored when removed. LPN #1 said, NJ Exec Order 26.4b1 is dated and changed weekly and stored in a bag when not in use.

During an interview with Surveyor #2 on 9/05/2023 at 11:44 AM, Unit Manager/Licensed Practical Nurse (UM/LPN) who said NJ Exec Order and NJ Exec Order 26.4b1 is changed once weekly on Monday 11-7 shift. She went on to say we store NJ Exec Orde in plastic bag when not in use. Surveyor #2 accompanied by the UM/LPN went to Resident #1's room. The surveyor and UM saw the

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F 880	Continued From page 46 NJ Exec Order 26.4b sitting on top of the machine uncovered and exposed. The UM/LPN confirmed it should be stored in a bag. UM/LPN also said that NJ Exec Orde and NJ Exec Orde are also stored in a bag when not in use. During an interview with Surveyor #2 on 9/06/2023 at 12:55 PM, the Director of Nursing (DON) was asked how NJ Exec Orde and NJ Exec Order 26.4b should be stored when not in use. The DON replied NJ Exec Orde and NJ Exec Order 26.4b should be stored in plastic bag when not in use. The DON was also asked how often NJ Exec Order 26.4b is NJ Exec Orde to be changed. The DON replied NJ Exec Order 26.4b1 is to be changed weekly and it is in as a physician order. A review of an undated facility policy titled "CPAP/BiPAP Support" did not address storage of the equipment. NJAC 8:39-19.4(k)	F 880		

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	061704	A. BUILDING: _____ B. WING _____	C 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG OAK REHABILITATION AND HEALTHCARE CENT	849 BIG OAK ROAD PITTSGROVE, NJ 08318

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments COMPLAINT # NJ 160885, NJ 165154 The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey for 1.) The weeks of 01/15/2023 to 01/28/2023, 2.) The weeks of 05/07/2023 to 05/13/2023, and 3.) The weeks of 08/06/2023 to 08/19/2023. Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112,	S 560	All residents have the potential to be affected by the deficient practice stated on the SOD A staffing and Recruitment/Retention committee including Director of Nursing, Staffing Coordinator, and Administrator/designees has been convened on 9/11/2023 and will meet 3x times a week to review retention efforts, open positions, recruitment tactics, and changes to improve outcomes staffing for upcoming week. The facility has contracts in place with multiple staffing agencies as an effort to provide additional staff when needed.	9/28/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/29/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061704	A. BUILDING: _____ B. WING _____	C 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG OAK REHABILITATION AND HEALTHCARE CENT	849 BIG OAK ROAD PITTSGROVE, NJ 08318

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 1 codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One (1) direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the 2 weeks of Complaint staffing from 01/15/2023 to 01/28/2023, the facility was deficient in CNA staffing for residents on 10 of 14 day shifts as follows: -01/15/23 had 7 CNAs for 77 residents on the day shift, required at least 10 CNAs. -01/17/23 had 8 CNAs for 76 residents on the day shift, required at least 9 CNAs. -01/18/23 had 7 CNAs for 76 residents on the day shift, required at least 9 CNAs. -01/19/23 had 7 CNAs for 76 residents on the day shift, required at least 9 CNAs. -01/21/23 had 7 CNAs for 76 residents on the day shift, required at least 9 CNAs. -01/22/23 had 7 CNAs for 77 residents on the day shift, required at least 10 CNAs. -01/23/23 had 5 CNAs for 77 residents on the day shift, required at least 10 CNAs.	S 560	The facility has secured an outside recruitment company to oversee recruitment tactics, open position and they participate in an interdisciplinary Quality Care Resource call to review open positions, recruitment tactics, and changes to improve outcomes. Contract staff utilization is reviewed bi- weekly to identify trends and opportunities. The facility has implemented a multifaceted approach for recruitment and retention of employees, Job fairs, Flexible scheduling, Increased utilization of PRN staff, Implementation of Hosted Time, Partnership with schools, Sign on bonuses, Referral bonuses, Pick-up shift bonuses, Rate adjustments, Benefit adjustments and Contract staff utilization. The administrator/designee will review the minutes from resident council to determine whether any concerns regarding care and services are identified monthly for two months and then quarterly. The results of Resident Council minutes as well as recruitment data will be reviewed by the Administrator or designee at the quarterly QAPI meeting. Compliance date: 9/28/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061704	A. BUILDING: _____ B. WING _____	C 09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG OAK REHABILITATION AND HEALTHCARE CENT	849 BIG OAK ROAD PITTSGROVE, NJ 08318

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 -01/24/23 had 9 CNAs for 77 residents on the day shift, required at least 10 CNAs. -01/27/23 had 9 CNAs for 78 residents on the day shift, required at least 10 CNAs. -01/28/23 had 9 CNAs for 78 residents on the day shift, required at least 10 CNAs. 2. For the weeks of Complaint staffing from 05/07/2023 to 05/13/2023, the facility was deficient in CNA staffing for residents on 4 of 7 day shifts as follows: -05/07/23 had 3 CNAs for 63 residents on the day shift, required at least 8 CNAs. -05/10/23 had 6 CNAs for 63 residents on the day shift, required at least 8 CNAs. -05/12/23 had 7 CNAs for 64 residents on the day shift, required at least 8 CNAs. -05/13/23 had 7 CNAs for 64 residents on the day shift, required at least 8 CNAs. 3. For the 2 weeks of staffing prior to survey from 08/06/2023 to 08/19/2023, the facility was deficient in CNA staffing for residents on 12 of 14 day shifts as follows: -08/06/23 had 6 CNAs for 74 residents on the day shift, required at least 9 CNAs. -08/07/23 had 8 CNAs for 73 residents on the day shift, required at least 9 CNAs. -08/09/23 had 8 CNAs for 73 residents on the day shift, required at least 9 CNAs. -08/10/23 had 6 CNAs for 72 residents on the day shift, required at least 9 CNAs. -08/11/23 had 5 CNAs for 72 residents on the day shift, required at least 9 CNAs. -08/12/23 had 7 CNAs for 72 residents on the day shift, required at least 9 CNAs. -08/13/23 had 7 CNAs for 72 residents on the day	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061704	A. BUILDING: _____ B. WING _____	C 09/07/2023

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S 560	Continued From page 3 shift, required at least 9 CNAs. -08/14/23 had 8 CNAs for 74 residents on the day shift, required at least 9 CNAs. -08/15/23 had 7 CNAs for 74 residents on the day shift, required at least 9 CNAs. -08/16/23 had 8 CNAs for 74 residents on the day shift, required at least 9 CNAs. -08/17/23 had 8 CNAs for 74 residents on the day shift, required at least 9 CNAs. -08/19/23 had 7 CNAs for 77 residents on the day shift, required at least 10 CNAs. During an interview with the survey team on 09/06/2023 at 12:53 PM, the Director of Nursing (DON) stated that she knows the staffing ratio requirements for CNA's: on days 1:8, evenings 1:10 an on nights 1:14. The DON added that "We are not meeting those requirements every day every shift." A review of the facility policy title, "Staffing, Sufficient and Competent Nursing with a revision date of April 2023, included, "Minimum staffing requirements imposed by the state, if applicable, are adhered to when determining staff ratio's ...	S 560		
S1405	8:39-19.5(a) Mandatory Infection Control and Sanitation a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for	S1405		9/28/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061704	A. BUILDING: _____ B. WING _____	C 09/07/2023

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S1405	Continued From page 4 up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees. This REQUIREMENT is not met as evidenced by: Based on interview and review of ten recently hired employee files, it was determined that the facility failed to ensure that 6 of 10 newly hired employees had completed a health history and received an examination by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant within two weeks prior to employment or upon employment. The deficient practice was evidenced as follows: On 09/06/23 at 09:10 AM, the surveyor reviewed the employee files of ten random recently hired individuals. Employee #2 was hired on [NJ Exec Order 26.4b1]; there was no employee health certificate/employee physical exam signed by a physician. Employee #4 was hired [NJ Exec Order 26.4b1]; there was no employee health certificate/employee physical exam signed by a physician. Employee #5 was hired [NJ Exec Order 26.4b1]; there was no employee health certificate/employee physical exam signed by a physician.	S1405	All residents have the potential to be affected by the deficient practice stated in the SOD. An audit was conducted on 9/6 by the administrator and with review of resident council minutes and no residents were affected by the deficient practice. Employee #2 #4 #7 #9 Stated on the Statement of deficiencies (SOD) Received their physicals on [NJ Exec] and Employee #5 received a physical on [NJ Exec]. An audit was conducted on 8/23/2023 and identified the issue stated on the Statement of deficiencies (SOD) of not having documentation of physicals being completed prior to hire. On 9/1/2023 the facility started a clinic to ensure proper compliance. The clinic will be ongoing weekly. On 9/6/2023 the administrator in-serviced the HR director and other department heads on proper on-boarding and proper file keeping of the HR files. An audit will be done by the Administrator/ HR Director weekly for 3 weeks and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S1405	Continued From page 5 Employee #7 was hired [redacted]; there was no employee health certificate/employee physical exam signed by a physician. Employee #9 was hired [redacted]; there was no employee health certificate/employee physical exam signed by a physician. On 09/06/2023 at 10:23 AM, during an interview with the surveyor, Human Resources Manager (HRM) confirmed that the employee files provided by her were complete and in its entirety. On 09/06/2023 at 10:23 AM, during an interview with the surveyor, the Human Resources Manager (HRM) confirmed that she provided the surveyor with all the employee files requested. The HRM added that the new employee must provide documentation of a physical within that year prior to hire and a Mantoux test within 6 months prior to hire. In an undated policy provided by the facility titled, "Employee Health Records," under #1; "A health record for each employee will contain, at a minimum: (b) employee physical;..."	S1405	monthly thereafter. A checklist was created for the HR files to ensure compliance. The results of the audits will be reported to the facility monthly QAPI committee meeting By the Administrator for one quarter to determine if sufficient compliance has been met. Based on the results of the audit the QAPI committee will determine continued need for the audit.	
S1410	8:39-19.5(b)(1) Mandatory Infection Control and Sanitation (b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine	S1410		9/28/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S1410	Continued From page 6 millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows: 1. If the first step of the Mantoux tuberculin skin test result is less than 10 millimeters of induration, the second step of the two-step Mantoux test shall be administered one to three weeks later. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that new employees consistently received the Mantoux tuberculin skin test (a test to check if a person has been infected with Tuberculosis bacteria) upon hire as required. This deficient practice was identified in 8 of 10 new employee files reviewed and is evidenced by the following: A review of Employee #1's file did not include documentation that she received step 1 or step 2 of the test upon hire on [redacted]. A review of Employee #2's file did not include documentation that she received step 1 or step 2 of the test upon hire on [redacted].	S1410	All residents have the potential to be affected by the deficient practice stated in the Statement of Deficiencies (SOD). An audit was conducted on 9/6 by the Administrator and with review of resident council minutes and no residents were affected by the deficient practice. Employees #1, #2, #3, #4, #5, #6, #7, and #9 in the Statement of Deficiencies (SOD) had their first step taken on [redacted] was read on [redacted] and step 2 taken on [redacted] and read on [redacted] An audit was conducted on 8/23/2023 and identified the issue stated on the SOD of not having documentation of physicals being completed prior to hire. On 9/1/2023 a facility wide clinic was held to ensure proper compliance. A checklist was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S1410	Continued From page 7 A review of Employee #3's file did not include documentation that she received step 1 or step 2 of the test upon hire on [NJ Exec Order 26.4b1] A review of Employee #4's file did not include documentation that she received step 1 or step 2 of the test upon hire on [NJ Exec Order 26.4b1]. A review of Employee #5's file did not include documentation that she received step 1 or step 2 of the test upon hire on [NJ Exec Order 26.4b1] A review of Employee #6's file did not include documentation that she received step 1 or step 2 of the test upon hire on [NJ Exec Order 26.4b1]. A review of Employee #7's file did not include documentation that she received step 1 or step 2 of the test upon hire on [NJ Exec Order 26.4b1] A review of Employee #9's file did not include documentation that she received step 1 or step 2 of the test upon hire on [NJ Exec Order 26.4b1] On 09/06/2023 at 10:23 AM, during an interview with the surveyor, the Human Resources Manager (HRM) confirmed that she provided the surveyor with all the employee files requested. The HRM added that the new employee must provide documentation of a physical within that year prior to hire and a Mantoux test within 6 months prior to hire. In an undated policy provided by the facility titled, "Employee Health Records," under #1; "A health record for each employee will contain, at a minimum: (c) associate TB (Mantoux) screening record."	S1410	created for the HR files to ensure compliance. On 9/6/2023 the administrator in-serviced the Nursing Management, HR Director and other department heads on proper on-boarding and proper file keeping of the HR files. An audit will be done weekly by the Director of Nursing/HR Director for 3 weeks and monthly thereafter. The results of the audits will be reported to the facility monthly QAPI committee meeting by the Director of Nursing/HR Director for one quarter to determine if sufficient compliance has been met. Based on the results of the audit the QAPI committee will determine continued need for the audit.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315014 Y1	A. Building B. Wing Y2	10/23/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG OAK REHABILITATION AND HEALTHCARE CENTER	849 BIG OAK ROAD PITTSGROVE, NJ 08318

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0558	Correction	ID Prefix F0689	Correction	ID Prefix	Correction
Reg. # 483.10(e)(3)	Completed	Reg. # 483.25(d)(1)(2)	Completed	Reg. #	Completed
LSC	09/15/2023	LSC	09/11/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
9/7/2023	☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315014 Y1	A. Building B. Wing Y2	10/23/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG OAK REHABILITATION AND HEALTHCARE CENTER	849 BIG OAK ROAD PITTSGROVE, NJ 08318

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0558	Correction	ID Prefix F0655	Correction	ID Prefix F0695	Correction
Reg. # 483.10(e)(3)	Completed	Reg. # 483.21(a)(1)-(3)	Completed	Reg. # 483.25(i)	Completed
LSC	09/15/2023	LSC	09/11/2023	LSC	09/11/2023
ID Prefix F0698	Correction	ID Prefix F0756	Correction	ID Prefix F0880	Correction
Reg. # 483.25(l)	Completed	Reg. # 483.45(c)(1)(2)(4)(5)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	09/15/2023	LSC	09/11/2023	LSC	09/20/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
9/7/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061704 Y1	A. Building B. Wing Y2	10/23/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG OAK REHABILITATION AND HEALTHCARE CENTER	849 BIG OAK ROAD PITTSGROVE, NJ 08318

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix S1405	Correction	ID Prefix S1410	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-19.5(a)	Completed	Reg. # 8:39-19.5(b)(1)	Completed
LSC	09/28/2023	LSC	09/28/2023	LSC	09/28/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
9/7/2023	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315014	A. BUILDING **01** B. WING _____	**09/07/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG OAK REHABILITATION AND HEALTHCARE CENTER	**849 BIG OAK ROAD** **PITTSGROVE, NJ 08318**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 09/06/2023 and 09/07/2023 Eagleview Health and Rehabilitation was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Eagleview Health and Rehabilitation a single story Type V unprotected building that was built in 1967. The facility is divided into 4 smoke zones. The facility has a Natural gas emergency generator.	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.	K 222		9/8/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/02/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315014	A. BUILDING **01** B. WING _____	**09/07/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG OAK REHABILITATION AND HEALTHCARE CENTER	**849 BIG OAK ROAD** **PITTSGROVE, NJ 08318**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 222	Continued From page 1 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315014	A. BUILDING **01** B. WING _____	**09/07/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG OAK REHABILITATION AND HEALTHCARE CENTER	**849 BIG OAK ROAD** **PITTSGROVE, NJ 08318**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 222	Continued From page 2 detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 09/06/2023, it was determined that the facility failed to provide 2 of 10 designated exit discharge doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. Findings include: On 09/06/2023 (day one of survey) during the survey entrance at approximately 9:05 AM, a request was made to the Regional Plant Operations Director (RPOD) and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms. A review of the facility provided lay-out identified the facility is a single-story building with ten (10) designated exit discharge doors (illuminated exit signs above doors) that Resident, Staff and Visitors would use in the event of an emergency to exit the building. Starting at approximately 9:18 AM on 09/06/2023 in the presence of the facility RDPO and MD a tour of the building was conducted. During the building at approximately 9:36 AM, the surveyor observed the main entrance two (2) sets of exit discharge doors (internal and external set of doors) revealed thumb turn lock on the egress side of the both doors. The thumb turn	K 222	All residents had the potential to be effected by the deficient practice stated on the Statement of deficiencies (SOD). On 9/6/2023 the deficient practice noted in the Statement of Deficiencies (SOD) was fixed by the Maintenance Director removing the locks from the doors. An audit was completed by the Maintenance Director on all exits doors on 9/7/2023 and no issues found. The administrator in serviced the maintenance director on 9/8/2023 on proper means of egress requirement. A monthly audit will be completed by the Maintenance Director and the results of the Audits will be brought to the Monthly QAPI committee to determine if additional audits are needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315014	A. BUILDING **01** B. WING _____	**09/07/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG OAK REHABILITATION AND HEALTHCARE CENTER	**849 BIG OAK ROAD** **PITTSGROVE, NJ 08318**

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K 222	Continued From page 3 lock and fastening device on the door could restrict emergency use of the exit. The RDPO and MD confirmed the findings at the times of observations. On 09/07/2023 during the survey exit at approximately 12:15 AM, the surveyor informed the Administrator of the deficiency. NJAC 8:39 -31.2 (e) NFPA 101 2012 - 7.2.1.6.1 (4).	K 222		
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 09/06/2023, in the presence of facility management it was	K 351	All residents had the potential to be affected by the deficient practice stated in the SOD.	10/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315014	A. BUILDING **01** B. WING _____	**09/07/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG OAK REHABILITATION AND HEALTHCARE CENTER	**849 BIG OAK ROAD** **PITTSGROVE, NJ 08318**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 351	Continued From page 4 determined that: 1) The Facility failed to properly install sprinklers, 2) Failed to provide fire sprinkler coverage to all areas of the facility as required by CMS regulation §483.90 (a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition The deficient practice is evidenced by the following, On 09/06/2023 (day one of survey) during the survey entrance at approximately 9:05 AM, a request was made to the Regional Plant Operations Director (RPOD) and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story building with forty-two (42) Resident sleeping rooms and common areas. Starting at approximately 9:18 AM on 09/06/2023 in the presence of the facility's RPOD and MD a tour of the building was conducted. Along the tour, the surveyor observed the following locations that failed to provide proper fire sprinkler coverage: 1) At approximately 10:24 AM, the surveyor observed outside in the Residents smoking area a 4'-4" by 19'-6" roof over hang extending over the patio area with no evidence of fire sprinkler coverage. 2) At approximately 10:35 AM, the surveyor	K 351	No residents were affected by the deficient practice stated in the Statement of Deficiencies (SOD). On 9/8/2023 The administrator, Reginal Director of plant ops reviewed the regulation stated on the Statement of Deficiencies (SOD) with the Maintenance Director and educated him on the regulation and created a checklist for the maintenance director to follow on his weekly rounds On 9/8/2023 Allied fire was contacted for a visit to install a new sprinkler system for the area stated on the Statement of deficiencies. On 10/16 sprinkler head was installed in the area identified on the Statement of Deficiencies (SOD). With this, the area now has proper fire sprinkler coverage. The maintenance director will conduct audits 2x a month for 3 months to ensure compliance. The results of the audits will be brought by the Administrator/Maintenance Director to the Monthly QAPI committee for one quarter to determine if compliance has been met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315014	A. BUILDING **01** B. WING _____	**09/07/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG OAK REHABILITATION AND HEALTHCARE CENTER	**849 BIG OAK ROAD** **PITTSGROVE, NJ 08318**

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K 351	Continued From page 5 observed inside Resident room #28 bathroom one (1) fire sprinkler missing an escheon cap. This left an approximately one (1) inch gap in the wallboard ceiling. With the missing escheon cap, in the event of a fire this would allow the heat to by-pass the fire sprinkler and take longer to activate. The facility failed to provide fire sprinkler coverage to all areas in the facility. The RDPO and MD confirmed the findings at the times of observations. On 09/07/2023 during the survey exit at approximately 12:15 AM, the surveyor informed the Administrator of the deficiency. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation on 09/06//2023, in the presence of facility management, it was determined that the facility failed to: 1) Perform a monthly examination for 3 of 20 portable fire extinguishers observed, as required by National Fire Protection Association as	K 355	All residents had the potential to be affected by the deficient practice stated in the Statement of Deficiencies (SOD). No residents were affected by the deficient practice stated in the SOD. On 9/8/2023 the Maintenance director inspected the 3 extinguishers stated on	9/22/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315014	A. BUILDING **01** B. WING _____	**09/07/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG OAK REHABILITATION AND HEALTHCARE CENTER	**849 BIG OAK ROAD** **PITTSGROVE, NJ 08318**

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K 355	Continued From page 6 required by NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70. Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 4- 3 Inspection Maintenance. - 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. - 4- 3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any conditions listed in 4- 3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. - 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. The findings include the following, On 09/06/2023 (day one of survey) during the survey entrance at approximately 9:05 AM, a request was made to the Regional Plant Operations Director (RPOD) and Maintenance Director (MD) to provide to provide a copy of the facility lay-put which identifies the various rooms and common areas for the Nursing facility. A review of the facility provided lay-out identified	K 355	the Statement of Deficiencies (SOD) to perform the monthly examination On 9/8 the Administrator in serviced the Maintenance Director on importance of inspecting each fire extinguisher monthly as stated in the regulation and document accordingly. On The administrator will conduct monthly audits for 3 months. The administrator will bring the results of the audits to the monthly QAPI committee for one quarter to determine if further auditing is needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315014	A. BUILDING **01** B. WING _____	**09/07/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG OAK REHABILITATION AND HEALTHCARE CENTER	**849 BIG OAK ROAD** **PITTSGROVE, NJ 08318**

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K 355	Continued From page 7 the building is a single-story building with a basement. Starting at approximately 9:18 AM on 09/06/2023 in the presence of the facility's RPOD and MD a tour of the facility was conducted. During the building tour the surveyor observed and inspected twenty (20) portable fire extinguishers in various locations that were last annually inspected in July 2023 with the surveyor observing the following issues that were identified: 1) At approximately 9:40 AM, One (1) "ABC-Type" fire extinguisher in the Front office area, last annually inspected July 2023. There was no evidence of monthly visual examination performed and documented for August 2023. 2) At approximately 10:39 AM, One (1) "ABC-Type" fire extinguisher in the corridor outside of Resident room #29, last annually inspected July 2023. There was no evidence of monthly visual examination performed and documented for August 2023. 3) At approximately 11:01 AM, One (1) "ABC-Type" fire extinguisher in the Resident Dining area, last annually inspected July 2023. There was no evidence of monthly visual examination performed and documented for August 2023. The RDPO and MD confirmed the findings at the times of observations. On 09/07/2023 during the survey exit at	K 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 355	Continued From page 8 approximately 12:15 AM, the surveyor informed the Administrator of the deficiency. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315014 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	10/23/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG OAK REHABILITATION AND HEALTHCARE CENTER	849 BIG OAK ROAD PITTSGROVE, NJ 08318

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0222	09/08/2023	LSC K0351	10/17/2023	LSC K0355	09/22/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
9/7/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO